2024 SUMMARY OF BENEFITS

COLORADO

Clear Spring Health

Clear Spring Health Essential (HMO)
H6379-001

COUNTIES: **Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Grand, Huerfano, Jackson, Jefferson, Larmier, Morgan, Park, Pueblo, Teller, Washington, Weld**

Clear Spring Health Essential (PPO)
H8014-001

COUNTIES: **Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson, Larimer, Weld**

Clear Spring Health

Summary of Benefits

This is a summary of health and drug services covered by Clear Spring Health Essential (HMO) from January 1, 2024 – December 31, 2024

Clear Spring Health has a contract with Medicare to offer HMO, PPO, and PDP plans. Clear Spring Health has contracts with the Georgia and South Carolina Medicaid programs. Enrollment in these plans is dependent on annual contract renewal with the federal government.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please visit www.clearspringhealthcare.com for the 2024 "*Evidence of Coverage*", or call 1-877-364-4566 to request a copy of the *Evidence of Coverage* to be mailed to you. The *Evidence of Coverage* will be available on our website by no later than October 15, 2023.

To join **Clear Spring Health Essential (HMO) or Clear Spring Health Essential (PPO)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area included the following counties in Illinois: Cook, DuPage, Kane, Kankakee, La Salle, McHenry, Will.

If you use the providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4277). TTY users should call 1-877-486-2048.

Call us or go online for more information.

Not yet a member? Call 1-877-364-4566 (TTY: 711)
From October 1st – March 31st, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m.
From April 1st – September 30th, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m.

Already a member? Call 1-877-364-4566 (TTY:711)
From October 1st – March 31st, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m.
From April 1st – September 30th, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m.

Website: clearspringhealthcare.com

Important Rules:
• In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

• Clear Spring Health offers a pharmacy network with preferred cost sharing at select pharmacies. You may pay more at other pharmacies. The Preferred Pharmacy Network is a select network of national and local independent pharmacies designed to help save you money on your prescriptions. You may choose non-preferred pharmacies to fill prescriptions, but your costs may be higher. Our pharmacy network may change at any time. You will receive notice when necessary.

• Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024

	Clear Spring Health Essential (HMO) H6379-001	Clear Spring Health Essential (PPO) H8014-001
	Benefits with a (+) may require prior authorization	
Monthly Plan Premium	$0 You must continue to pay your Medicare Part B premium.	$0 You must continue to pay your Medicare Part B premium.
Deductibles	$0	$0
Maximum Out-of-Pocket	$3,400	**In-Network** $5,500 **Combined MOOP IN and OUT of Network** $8,950
Inpatient Hospital Coverage - Acute (+)	$150 copay per day for days 1-5; $0 copay per day for days 6-90	**In-Network** $300 copay per day for days 1-5; $0 copay per day for days 6-90 **Out-of-Network** 45% of the total cost per day for days 1-5; 0% of the total cost per day for days 6-90
Inpatient Hospital Coverage - Psychiatric (+)	$150 copay per day for days 1-5; $0 copay per day for days 6-90	**In-Network** $275 copay per day for days 1-6; $0 copay per day for days 7-90 **Out-of-Network** 45% of the total cost per day for days 1-6; 45% of the total cost per day for days 7-90
Outpatient Hospital Coverage (+)	$40 to $150 copay $40 copayment for some skin tag removals performed at a dermatologists office. $150 copayment for all other services. Authorization required for Medicare-covered Observation Services after the first 24 hours	**In-Network** $45 to $340 copay $45 copayment for some skin tag removals performed at a dermatologists office. $340 copayment for all other services. Authorization required for Medicare-covered Observation Services after 24

	Clear Spring Health Essential (HMO) H6379-001	Clear Spring Health Essential (PPO) H8014-001
		hours **Out-of-Network** 45% of the total cost
Ambulatory Surgical Center (ASC) Services (+)	$40 to $100 copay $40 copayment for some skin tag removals performed at a dermatologists office. $100 copayment for all other services.	**In-Network** $45 to $290 copay $45 copayment for some skin tag removals performed at a dermatologists office. $290 copayment for all other services. **Out-of-Network** 45% of the total cost
Doctor Visits (Primary Care Providers and Specialists) (+)	$0 copay for PCP visits $0 to $20 copay for Specialist visits. $0 copay for Endocrinologist Specialist. $20 copay for all other Specialists.	**In-Network** $0 copay for PCP visits $0 to $20 copay for Specialist visits. $0 copay for Endocrinologist Specialist. $20 copay for all other Specialists. **Out-of-Network** 45% of the total cost for PCP visits 45% of the total cost for Specialist visits
Preventative Care (e.g., Flu Vaccine, Diabetic Screenings, Annual Wellness Visit)	$0 copay	**In-Network** $0 copay **Out-of-Network** 45% of the total cost
Emergency Care	$90 copay ER cost sharing is not waived if you are admitted to the hospital for the same condition.	$90 copay ER cost sharing is not waived if you are admitted to the hospital for the same condition.

	Clear Spring Health Essential (HMO) H6379-001	Clear Spring Health Essential (PPO) H8014-001
Urgently Needed Services	$35 copay Urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition.	$30 copay Urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition.
Diagnostic Services/Labs/Imaging Diagnostic tests and procedures Lab Services Diagnostic radiology Outpatient x-rays (+)	Diagnostic Tests and Procedures: $0 copay Lab Services: $0 copay Diagnostic Radiology: $20 to $175 copay $20 copayment for some diagnostic ultrasound and diagnostic bone density imaging. $175 copayment for all other Diagnostic Radiological Services (e.g., CT, MRI) Outpatient X-rays: $0 copay	**In-Network** Diagnostic Tests and Procedures: $0 copay Lab Services: $0 copay Diagnostic Radiology: $20 to $175 copay $20 copayment for some diagnostic ultrasound and diagnostic bone density imaging. $175 copayment for all other Diagnostic Radiological Services (e.g., CT, MRI) Outpatient X-rays: $20 copay **Out-of-Network** Diagnostic Tests and Procedures: 45% of the total cost Lab Services: 45% of the total cost Diagnostic Radiology: 45% of the total cost Outpatient X-rays: 45% of the total cost

	Clear Spring Health Essential (HMO) H6379-001	Clear Spring Health Essential (PPO) H8014-001
Hearing Services Routine Hearing Exam Hearing Aids	$0 copay for Medicare-covered hearing exams $0 copay for routine, non-Medicare covered hearing exams. $500 maximum plan coverage amount every year (per ear) for hearing aids. 2 hearing aids every year Routine hearing services, including hearing aids, are available only through NationsBenefits. Routine Hearing Exams and Hearing Aids are Not covered Out-of-Network.	**In-Network** $0 copay for Medicare-covered hearing exams **Out-of-Network** 45% coinsurance for Medicare-covered hearing exams $0 copay for routine, non-Medicare covered hearing exams. $500 maximum plan coverage amount every year (per ear) for hearing aids. 2 hearing aids every year Routine hearing services, including hearing aids, are available only through NationsBenefits.
Dental Services	1 oral exam every 6 months, $0 copay 1 cleaning every 6 months, $0 copay 1 fluoride treatment every year, $0 copay $0 copay for Endodontic, Periodontic, Extractions, Prosthodontics/ and other Oral and Maxillofacial surgeries $2,000 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services.	1 oral exam every 6 months, $0 copay 1 cleaning every 6 months, $0 copay 1 fluoride treatment every year, $0 copay $0 copay for Endodontic, Periodontic, Extractions, Prosthodontics/ and other Oral and Maxillofacial surgeries $1,500 maximum plan coverage amount every year for in- and out-of-network non-Medicare-covered comprehensive dental services. **Out-of-Network** 45% of the total cost for comprehensive dental services up to the maximum amount.

	Clear Spring Health Essential (HMO) H6379-001	Clear Spring Health Essential (PPO) H8014-001
Vision Services	$0 copay for Medicare-covered eye exam **Non-Medicare Vision Services** 1 routine vision exam every year at $0 copay 1 pair of eyeglasses every year $250 maximum plan coverage amount for all non-Medicare-covered eyewear per year.	**In-Network** $0 copay for Medicare-covered eye exam **Out-of-Network** 45% of the total cost **Non-Medicare Vision Services** 1 routine vision exam every year at $0 copay $150 maximum plan coverage amount for all non-Medicare-covered eyewear per year. **Out-of-Network** 45% of the total cost for routine eye exam Eyeglasses: 45% of the total cost for Medicare-covered eyeglasses
Mental Health Services	$20 copay for individual sessions $20 copay for group sessions	**In-Network** $40 copay for individual sessions **Out-of-Network** 45% of the total cost for individual sessions **In-Network** $40 copay for group sessions **Out-of-Network** 45% of the total cost for group sessions

	Clear Spring Health Essential (HMO) H6379-001	Clear Spring Health Essential (PPO) H8014-001
Skilled Nursing Facility (+)	$0 copay per day for days 1-20; $178 copay per day for days 21-100	**In-Network** $0 copay per day for days 1-20; $178 copay per day for days 21-100 **Out-of-Network** 45% of the total cost per day for days 1-20; 45% of the total cost per day for days 21-100
Physical Therapy (+)	$40 copay	**In-Network** $40 copay **Out-of-Network** 45% of the total cost
Ambulance (+)	$200 copay for ground ambulance transportation $200 copay for air transportation Prior authorization is required for non-emergency Medicare ground transportation services.	**In-Network** $270 copay for ground ambulance transportation **Out-of-Network** $275 to $275 copay for ground ambulance transportation **In-Network** $270 copay for air transportation **Out-of-Network** $275 to $275 copay for air transportation Prior authorization is required for non-emergency Medicare ground transportation services.

	Clear Spring Health Essential (HMO) H6379-001	Clear Spring Health Essential (PPO) H8014-001
Transportation (+)	Up to 12 round trips every year to plan-approved health-related locations	**In-Network** Up to 12 round trips every year to plan-approved health-related locations. **Out-of-Network** Not covered
Medicare Part B Drugs	20% of the total cost for Insulin 20% of the total cost for Chemotherapy 20% of the total cost for Other Part B drugs	**In-Network** 0% to 20% of the total cost for Insulin **Out-of-Network** 45% of the total cost for Insulin **In-Network** 0% to 20% of the total cost for Chemotherapy **Out-of-Network** 45% of the total cost for Chemotherapy **In-Network** 0% to 20% of the total cost for Other Part B drugs **Out-of-Network** 45% of the total cost for Other Part B drugs

Clear Spring Health

	PRESCRIPTION DRUGS Clear Spring Health Essential (HMO) H6379-001				
Deductible	**$0**				
Initial Coverage Limit	You are in the Initial Coverage Stage until your total yearly drug costs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and the plan.				
Coverage Gap	The plan does not provide additional coverage gap. You stay in the Initial Coverage Stage until your out-of-pocket costs reach **$8,000**. Not everyone will enter the coverage gap. You will then move on to the Catastrophic Coverage Stage.				
Catastrophic Stage	During the Catastrophic Coverage Stage, the plan pays the full cost of your covered Part D drugs. You pay nothing.				
Pharmacy Type	Preferred Retail 30-day supply	Non-Preferred Retail 30-day supply	Preferred 90-day supply	Non-Preferred 90-day supply	Preferred Mail Order 30-day supply
Tier 1: Preferred Generic	$0 copay	$9 copay	$0 copay	$0 copay	$0 copay
Tier 2: Generic	$0 copay	$12 copay	$0 copay	$36 copay	$0 copay
Tier 3: Preferred Brand	$42 copay	$47 copay	$126 copay	$141 copay	$42 copay
Tier 4: Non-Preferred Drug	$95 copay	$100 copay	$285 copay	$300 copay	$95 copay
Tier 5: Specialty	33% of the total cost	33% of the total cost	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	33% of the total cost

Clear Spring Health

	PRESCRIPTION DRUGS Clear Spring Health Essential (PPO) H8014-001				
Deductible	**$0**				
Initial Coverage Limit	You are in the Initial Coverage Stage until your total yearly drug costs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and the plan.				
Coverage Gap	The plan does not provide additional coverage gap. You stay in the Initial Coverage Stage until your out-of-pocket costs reach $8,000. Not everyone will enter the coverage gap. You will then move on to the Catastrophic Coverage Stage.				
Catastrophic Stage	During the Catastrophic Coverage Stage, the plan pays the full cost of your covered Part D drugs. You pay nothing.				
Pharmacy Type	Preferred Retail 30-day supply	Non-Preferred Retail 30-day supply	Preferred 90-day supply	Non-Preferred 90-day supply	Preferred Mail Order 30-day supply
Tier 1: Preferred Generic	$0 copay	$9 copay	$0 copay	$0 copay	$0 copay
Tier 2: Generic	$0 copay	$14 copay	$0 copay	$42 copay	$0 copay
Tier 3: Preferred Brand	$42 copay	$47 copay	$126 copay	$141 copay	$42 copay
Tier 4: Non-Preferred Drug	$95 copay	$100 copay	$285 copay	$300 copay	$95 copay
Tier 5: Specialty	33% of the total cost	33% of the total cost	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	33% of the total cost

	H6379_001 Clear Spring Health Essential (HMO)	H8014-001 Clear Spring Health Essential (PPO)
	ADDITIONAL BENEFITS	
Over the Counter	$87 maximum plan coverage amount per month for OTC items. OTC items are available online through NationsBenefits or at participating network retailers. Unused portion does not carry over to the next period. **Out-of-Network** Not covered	$92 maximum plan coverage amount per month for OTC items. OTC items are available online through NationsBenefits or at participating network retailers. Unused portion does not carry over to the next period. **Out-of-Network** Not covered
Utilities (General Supports for Living)	$75 per month for gas, electric, water, or internet. Monthly telephonic contact required, along with a copy of the receipt. Amount does not rollover.	Not offered.
Special Supplemental Benefits for the Chronically Ill	**$125** per month for groceries. A completed health risk assessment, indicating a qualifying chronic condition is required. Groceries are available through NationsBenefits or from participating network retailers. Unused portion does not carry over to the next period.	**$125** per month for groceries. A completed health risk assessment, indicating a qualifying chronic condition is required. Groceries are available through NationsBenefits or from participating network retailers. Unused portion does not carry over to the next period.

Important Message About What You Pay for Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on at any in-network pharmacy, or $30 for a month supply of each insulin product covered by our plan at a preferred pharmacy.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Your cost share may differ depending on when you enter another phase of the drug benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday through Friday, 7 a.m. – 7 p.m. TTY users should call 1-800-325-0778. For more information on additional pharmacy specific cost-share and the drug coverage stages, please call our Customer Service department, or access our "Evidence of Coverage" online or request one by mail.